## Geriatric Outpatient Services – Toronto Rehab

<table>
<thead>
<tr>
<th>Service</th>
<th>Criteria for referral</th>
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| **Geriatric Day Hospital**             | • Outpatient rehab for patients over the age of 65 requiring two or more of the following services: nursing, physiotherapy, occupational therapy, social work, speech-language pathology, therapeutic recreation  
• 12-week duration, 2 sessions per week  
• Appropriate for patients with complex physical/psychosocial concerns  
• Program is individualized to each patient  
• Medical management overseen by a geriatrician  
**Exclusion Criteria:**  
• Require more than 1 person assistance for transfers/ambulation  
• Cognitive difficulties preventing patient participation |
| **Falls Prevention Program**           | • Interprofessional assessment by geriatrician, physiotherapist and nurse  
• 12-week duration, 1 session per week including educational lecture and group exercise class  
• Appropriate for patients over the age of 65 at risk for falls  
• Patient must be able to participate in group exercises and learn new information  
**Exclusion Criteria:**  
• Cognitive or medical issues that would impair participation in group exercise  
• Requires assistance or supervision with transfers or ambulation |
| **Geriatric Medicine Clinic**          | • Comprehensive assessment by a geriatrician (nursing and social work available as needed)  
• Common reasons for referral include:  
  ◦ Cognitive impairment  
  ◦ Complex medical problems and polypharmacy  
  ◦ Functional decline or falls |
| **Geriatric Psychiatry Clinic**        | • Consultation by a geriatric psychiatrist  
• Common reasons for referral include:  
  ◦ Depression, Anxiety  
  ◦ Agitation, Aggression  
  ◦ Delusions, Hallucinations |
| **Independence at Home (IAH) Community Outreach Team** | • Multi-disciplinary assessment, care plan development and coordination (team members may include RN, OT, PT, Pharmacy, SW, MD based on patient’s needs)  
• Appropriate for medically and socially complex, community dwelling seniors who have experienced recent functional decline and have potential to regain function or may be struggling for other reasons to remain in the community – i.e. poor connections to community services. Ideal for more home-bound seniors.  
• May include an in-home assessment based on patient’s needs  
• The team will create a comprehensive care plan and connect patients to appropriate rehabilitation services (e.g., in-home therapy, community exercise programs, specialized geriatric rehab programs such as FALLS Prevention Program, Geriatric Day Hospital, Inpatient Geriatric Rehab, or Convalescent Care) as well as other home and community supports that can help maintain their independence.  
**Catchment:** South of St Clair Avenue and O’Connor Drive., West of Greenwood Ave., and East of Dufferin Ave. |

Please fax referral and related **consultation notes, current medication list and recent investigations** to (416) 597-7066.

For questions or concerns regarding the IAH Community Outreach Team please contact (416) 597-3422 x3830. For questions or concerns regarding any other Geriatric Outpatient Service please contact (416) 597-3422 x3065.

** Toronto Rehab/UHN is a teaching hospital. Trainees may be involved in your care. **
# Referral Form

**Geriatric Outpatient Services - Toronto Rehab**

Please indicate to which service the patient is being referred. Please note that during the referral review process, patients may be redirected to another of the listed Geriatric Outpatient services if more appropriate. (please refer to p. 1 for service descriptions)

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<tr>
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<tbody>
<tr>
<td>Geriatric Day Hospital</td>
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<tr>
<td>Falls Prevention Program</td>
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### Patient Information

- **Name of Patient:** ___________________________  
  - **Last Name:** ___________________________  
  - **First Name:** ___________________________  
  - **DOB:** mm/dd/yyyy  
  - **M**  
  - **F**
- **Address:** ___________________________  
  - **City:** ___________________________  
  - **Postal Code:** ____________
- **Phone:** ___________________________  
  - **Health Card #:** ___________________________
- **Emergency Contact:** ___________________________  
  - **Relationship:** ___________________________  
  - **Tel:** ___________________________
- **Contact to Arrange Appointment:**  
  - **Client**  
  - **Alternate Contact**  
  - **Does client speak English?**  
    - **Yes**  
    - **No**  
    - If No, indicate language:
- **Has the patient/family been informed of this referral?**  
  - **Yes**  
  - **No**
- **Has the patient been seen by a Geriatrician?**  
  - **Yes**  
  - **No**
- **Transfers:**  
  - **Independent**  
  - **Assistance**  
  - **Not sure**
- **Ambulation:**  
  - **Independent**  
  - **Assistance**
- **Mobility Aid:** ___________________________

### Main Concern(s) to Address

- **Has diagnosis been discussed with patient?**  
  - **Yes**  
  - **No**

### Medical History / Medication List

- **□ Documentation Attached**

### Reasons for Referral

- **□ Medical**  
  - Complex comorbidity
  - Medication management
  - Pain management
  - Sleep
  - Constipation
  - Incontinence
  - Swallowing
  - Weight loss/nutrition
- **□ Cognitive/Behavioural**  
  - Cognitive impairment
  - Depression
  - Verbal/physical aggression
  - Delusions/hallucinations
- **□ Psychosocial**  
  - Caregiver issues
  - Social isolation
  - Elder abuse
- **□ Functional decline**  
  - Mobility/falls
  - Speech difficulties
- **□ Other:** ___________________________

### Please attach the following documentation:

- **□ Brain imaging (if available)**
- **□ Bone Mineral Density (if available)**
- **□ Relevant consultation reports (e.g., cardiology, neurology, geriatrics, etc.)**
- **□ Blood work**

### Contacts

- **Family MD:** ___________________________  
  - **Billing #:** ___________________________  
  - **Phone:** ___________________________  
  - **Fax:** ___________________________
- **Referring MD/NP:** ___________________________  
  - **Billing #:** ___________________________  
  - **Phone:** ___________________________  
  - **Fax:** ___________________________
- **Signature of Referring MD/NP:** ___________________________  
  - **Date:** ___________________________

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Please fax the completed referral and accompanying documentation to (416) 597-7066